Department of Veterans Affairs

Veterans' Families, Caregivers, and Survivors Federal Advisory Committee Planning Meeting

October 23 – October 24, 2017

Washington, DC

9:00AM – 5:00PM

Attendees:

Committee Members Present:
Senator Elizabeth Dole, Committee Chair
Mary Buckler
Bonnie Carroll
Melissa Comeau
Harriet Dominique
Jennifer Dorn
Ellyn Dunford
Mary Keller
Robert Koffman, MD
Michael Linnington, MG, USA, Ret.
Yvonne Riley
Joe Robinson
Elaine Rogers
Loree Sutton, BG, USA, Ret.
Francisco Urena
Shirley White
Lolita Zinke

Committee Members Absent:
Sherman Gillums, Committee Vice Chair
Lee Woodruff

Department of Veterans Affairs Staff Presenters:
Dr. David Shulkin, Secretary of Veterans Affairs (VA)
Carol Borden, Deputy Ethics Official, Office of General Counsel
Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration (VHA)
Dr. Lynda Davis, Chief Veterans Experience Officer
Moira Flanders, Director, Office of Survivor Assistance
Kevin Friel, Assistant Director, Pension and Fiduciary Service
Christine Merna, Designated Federal Officer (DFO)
Jeffrey "Boomer" Moragne, Director, Advisory Committee Management Office
Laura O'Shea, Designated Federal Officer (DFO)
James Ruhlman, Assistant Director for Policy and Procedures, Education Service
Dr. Kenneth Shay, Designated Federal Officer (DFO)
Debra Walker, Designated Federal Officer (DFO)

Ron Walters, Interim Under Secretary for Memorial Affairs
Barbara Ward, Director of Center for Minority Veterans
Kayla Williams, Director of Center for Women Veterans

Monday, October 23, 2017

9:15 AM – 9:30 AM Opening Remarks *Secretary David Shulkin*	**SUMMARY:** • Dr. David Shulkin, Secretary of VA, thanked committee members for attending and Senator Elizabeth Dole for agreeing to act as Chair. • Secretary Shulkin recognized the need for a forum for families, caregivers, and survivors to share their experiences and influence future policies. • Dr. Lynda Davis, Chief Veterans Experience Officer, reached out to Secretary Shulkin to convene a Federal Advisory Committee so they may formalize a process to receive input from families, caregivers, and survivors and move toward embracing the community, providing improved support, and ultimately improving service delivery to Veterans. • Secretary Shulkin's vision for VA is a proactive organization. He plans to push through barriers to enacting change. o Secretary Shulkin encouraged attendees to be bold and put forward ideas that may not seem practical. He recognized the importance of the work to be done by the committee. • One of VA's primary objectives is to ensure the Veteran can choose care at home over institutional care, whether this is at the end of life or at any other point in their care journey. o Using the models of care in the VA system, including home-based care, remote monitoring, telehealth platforms, and caregiver and family support, along with other social support mechanisms, VA can design a system in which no Veteran needs to leave his or her home unless they choose to receive outside services. o Secretary Shulkin noted that the committee could accelerate means to achieve this goal.
9:30 AM – 9:40 AM Opening Remarks *Senator Elizabeth Dole*	**SUMMARY:** • Senator Dole thanked Secretary Shulkin for convening the committee and allowing the group to delve into the challenges facing families, caregivers, and survivors. • Senator Dole noted that the charter of the committee may read to advise the Secretary of VA, but ultimately, they are accountable to the American public—the families, caregivers, and survivors of veterans who are depending on the committee to be their voice. • Senator Dole noted some key principles for the success of the committee: o Members are not there as advocates for their respective organizations, rather to represent the network of loved ones supporting America's veterans. o Members should be solutions-focused and results-oriented, with an active effort to reach consensus. o Members should not hesitate to raise difficult problems and are not to back down in searching for answers. • Senator Dole noted she has worked with many teams tasked with complex challenges. They tackled issues that were urgent, currently solvable and which would have the biggest impact. • She emphasized that cultural change in the largest integrated health care system in the United States will not be easy, but there is no limit to what a dedicated group of people can attain.

	• Senator Dole noted that consideration of stakeholders would be essential, including those within VA and outside of the system, such as non-profit organizations, state and local governments, and local communities.

9:40 AM – 10:10 AM Member Introductions *Committee Members*	**SUMMARY:** • Jennifer "Jenna" Dorn: Chief Executive Officer, American Academy of Physicians Assistants • Harriet Dominique: Senior Vice President, USAA, noted being a contrarian and civilian voice • Francisco Urena: Massachusetts State Director of Veterans Affairs • Shirley White: Retired Public School Educator, who works with Gold Star mothers in West Virginia. She lost two sons in 2005 (in service) and 2008 (in a VA facility). She hopes to take information back to survivors about what services are available. • Mary Keller: President and CEO of Military Child Education Coalition, wife of a deceased Veteran and mother of a Veteran • Yvonne Riley: Caregiver for 20 years • Loree Sutton, BG, USA, Ret.: NYC Commissioner of Veterans Affairs • Melissa Comeau: Caregiver for her husband, Fellow for Elizabeth Dole Foundation, involved in the Veteran Caregiver Network • Mary "Dubbie" Buckler: National Secretary/Executive Director, American Legion Auxiliary, noted being one of the biggest advocates of VA • Lolita Zinke: VA customer, wife of a Navy SEAL Veteran, mother of a former Navy diver currently using VA for educational support, noted interest in supporting Native American and rural populations and providing care in their communities • Ellyn Dunford: Spouse of the current Chairman of the Joint Chiefs of Staff, with over 40 years of service, noted her experience of 30 years as a Physical Therapist • Joe Robinson: Senior Vice President, Philips, health care professional whose brother served in Vietnam, noted his business viewpoint and interest in health care in the home • Robert "Bob" Koffman, MD: Recently retired Naval officer who is working with a national center of excellence to develop a premier clinical model for PTSD and TBI, acts as Medical Director for Semper Fi fund, noted that as a 100% disabled Veteran, membership on the committee is real and personal • Michael Linnington, MG, USA, Ret.: Chief Executive Officer, Wounded Warrior Project, which focuses on holistic healing and is dedicated to providing care in the home • Elaine Rogers: President of USO for 41 years • Bonnie Carroll: President and Founder of Tragedy Assistance Program for Survivors (TAPS), founded in 1994, she is a Veteran • Sherman Gillums (via telephone): Executive Director of Paralyzed Veterans of America, noted he was paralyzed while in uniform, and his wife, who is his caregiver is a previous Elizabeth Dole Foundation Fellow
10:10 AM – 10:30 AM Presentation of Certificates *Dr. Lynda Davis and Christine Merna*	

10:30 AM – 10:40 AM
Advisory Committee Management Office, Committee Training
 	
Jeffrey Moragne
	SUMMARY:
	• Jeffrey Moragne, Director, VA Advisory Committee Management Office, provided training on Federal Advisory Committee structure and decorum.
	• The Advisory Committee Management Office provides oversight for all VA Federal Advisory Committees.
	• Key guidance included:
	  o A Designated Federal Officer (DFO) must be in the room.
	  o The public needs to be able to see proceedings and participate.

	○ The committee needs a quorum to meet. ○ Notification to close meetings must be provided ahead of time, along with the justification (e.g., testimonies of a personal nature). ○ The public is not able to attend workgroup meetings. ○ Members cannot testify as a representative of the committee; they can testify with personal opinion. ○ Committee members can expect to serve two terms (four years) at most. ○ Recommendations to the Secretary should be in consensus. ○ Reports should have Specific, Measurable, Actionable, Realistic, and Time bound (SMART) recommendations. • Mr. Moragne encouraged cross-committee collaboration.
10:40 AM – 11:25 AM Ethics Training *Carol Borden*	**SUMMARY:** • Carol Borden, Deputy Ethics Official, Office of General Council, presented ethics training for Special Government Employees. • Ms. Borden explained that her team is available to assist in mitigating any conflicts of interest, both actual and perceived.
11:25 AM – 12:00 PM Opening Remarks, Chief Veterans Experience Officer *Dr. Lynda Davis*	**SUMMARY:** • Dr. Davis opened with her background as a Veteran, mother of a Service Member, and both a caregiver and survivor. • She noted that this Federal Advisory Committee is an opportunity to push forward on the outstanding needs of families, caregivers, and survivors. • Dr. Davis explained that she is the Chief Customer Service Officer, a first of its kind in a federal organization; she recognizes that not everyone has a good experience with VA, but she wants to work toward improving it. • Choose Home is a new initiative designed to allow Veterans to remain in their homes over institutional care and this initiative will employ research and action to improve the experience of Veterans and their families. • The Veterans Experience Officer aims to assist VA to improve experiences in health care delivery, benefits, and services throughout the continuum of care, outlined via the Veteran Journey Map. • The group examined the Veteran Journey Map, and Dr. Davis encouraged committee members to use it to guide their thinking regarding the different stages for families, caregivers, and survivors. • At each stage of the Veteran's care journey, there are key issues. • Rural populations (both tribal and non-tribal) are a focus; these populations cannot access facilities and may not be close to family. ○ VA is exploring the use of telehealth to reach caregivers of isolated Veterans in rural communities. • Dr. Davis discussed how to reach those cut off in other ways (i.e., those isolated by their habits and going out into the community). • Research has identified the issues of accessibility, awareness, and use of resources. It is not enough to have the resources available; they must also be accessible and families, caregivers, and survivors must be aware of them. • Respite is a key resource for caregivers, which RAND Corporation has studied. • The invisible wounds of war affect caregivers and family members as well, including secondary PTSD diagnoses. • Dr. Davis introduced the group to representatives of Centers of Excellence available for collaboration, including Survivor Assistance, Minority Veterans, Women Veterans, Faith-Based and Community Partnerships, and Benefits. ○ Benefits are a concern, and recommendations may relate to funding or

	navigation (i.e., access and utilization of resources). o Community partners may have independence programs that could pair well with services provided by VA. • Dr. Davis asked the committee to first look at priorities broadly, and then begin to narrow down focus. **QUESTIONS:** • Dr. Koffman asked how the experience might be different from the Journey Map for catastrophically injured Veterans. o Dr. Davis noted the Journey Map was a synthesis effort for all different types of Veteran experiences. She recommended considering recommendations specific to stakeholder groups, as well as large-scale recommendations. • Ms. Comeau suggested the group consider other groups of Veterans, including those not catastrophically injured. She thought the committee should instead engage with the viewpoint that not all Veterans are entirely disabled, and all Veterans deserve support. o Dr. Davis noted there are a majority of Veterans who are not catastrophically injured, and it will be key to think of all different stakeholders. • Ms. Dunford emphasized that the image of Veterans in public reports should be one of empowerment, while in the past some reports may have characterized them in a certain way to ensure services were provided. • Mr. Gillums (via telephone) agreed that the committee should not adopt the Veteran as a victim viewpoint, but still show the reality of Veterans who have lost limbs—the face of the military and the consequences. o He noted there are Veterans that require specialized services and are highly disabled; the key will be balance and consideration of objective scales that delineate the specific category in which a Veteran falls.
12:00 PM – 1:00 PM	Lunch
1:00 PM – 1:10 PM Public Comment	The committee recognized a public comment from a caregiver who had to leave early and could not attend public comments session. • Ms. Megan Morseth from Indiana spoke to the importance of Chronic Traumatic Encephalopathy (CTE) and the need for recognition of Mild Traumatic Brain Injury (MTBI) in VA service delivery. A condition sustained from a number of concussive blasts and subsequent shockwaves, this issue is an epidemic facing VA and caregivers. She asked the committee to consider why VA makes physical wounds the top priority. She told the story of her husband. VA clinicians wrote in his medical file that he was a narcissistic alcoholic. However, she noted that 60% of those with MTBI have been diagnosed with a substance abuse disorder. She said a community-based neurologist uncovered that the substance use was related to his neurologic condition, and his drinking stopped. She noted his wounds are invisible, but the weight of the condition is always there. She asked the community to make this a priority on behalf of all Veterans and caregivers living with MTBI.
1:10 PM – 1:45 PM Overview of Veterans Health Administration (VHA) *Dr. Carolyn Clancy*	**SUMMARY:** • Dr. Carolyn Clancy, Executive in Charge, VHA, provided an overview of VHA in relation to families, caregivers, and survivors. She spoke to the size of the system, the mission-driven nature of their employees, as well as the issue of bureaucracy. • Dr. Clancy noted that Veteran-centered care is a priority. She noted capacity, capability, and consistency were the foundational components for excellence. Consistency of best practices across VHA is important. • In terms of the Veterans Choice Program, VHA has been working with Congress to ensure they are moving beyond administrative criteria. They want to focus on needs identified by each Veteran.

- The first question is whether a service is available for a Veteran through VA services. The next question is whether that service is accessible.
- Telehealth is a key technique for VA. Telehealth can be used within a state and within VA facilities, but they are investigating working across state lines and across locations (e.g., a Veteran's home).
- Dr. Clancy drew the committee's attention to Veterans Appointment Request, an online tool VHA is developing to make it easier for Veterans to get an appointment.
- VHA has been emphasizing assistance for Veterans with mental health disorders; it is a public health priority as well as a priority for the Secretary.
  - Veterans who commit suicide are often those not connected to the system, or have not been connected for a number of years. There are also large numbers of suicide among older to middle age Veterans.
  - Carolyn Clancy noted that Vet Centers can be helpful in connecting Veterans to care.
- Making sure we do well at every single point of the system is a priority for VHA, and ensuring trust in VA care among Veterans is key for clinical outcomes.
- Dr. Clancy noted that families and caregivers are an essential part of the clinical care process. She noted respite care and mobility concerns in particular.
- Dr. Clancy expressed that VHA could not provide the best possible health care without the feedback of families and caregivers; she said if something is working well, VHA wants to hear about it, and if it is not working well, they want to hear about it even more.
- A specialized center within VA did a systematic review of caregiver support, and their conclusion was that more research is needed.

QUESTIONS:

- Ms. Dunford suggested that the organizations represented by the committee should connect with their local Vet Centers and form relationships.
  - Ms. Carroll noted that TAPS connects survivors with counseling through Vet Centers.
  - Mr. Urena commended Vet Centers in providing flexible support services for Veterans as well as their families.
- Dr. Koffman asked how clinicians' cultural competency is assessed; Dr. Clancy noted that there are surveys done to ask how well Veterans feel their clinician knows them, as well as a pilot in which Veterans volunteer to carry recorders in order to assess their clinician's cultural competency.
  - Dr. Davis said they have developed a training to assist clinicians to connect with Veterans, which will be rolled out across the system.
- Senator Dole asked how often caregivers are allowed in rooms during treatment and whether this differs across the system. Dr. Clancy noted that it is likely inconsistent, potentially due to privacy concerns, though she believes physicians would welcome it.
- Ms. Buckler asked how complementary and alternative therapies are considered, such as art and performance therapy.
  - Ms. Dunford suggested fostering connections to those providing therapies in Veterans' local areas.
  - Dr. Clancy expressed that VHA welcomes complementary, integrated treatments; the Center for Compassionate Innovation is dedicated to going the extra mile to determine what VHA can do for Veterans.
- Ms. Dorn asked Dr. Clancy what the priority would be for VHA in this area.
  - Dr. Clancy noted that developing a system of how VHA can receive feedback from families and caregivers, in a manner easier for them, is a priority.

	• BG Sutton noted that the committee should thank Ms. Morseth and continue to connect with families, caregivers, and survivors present in relation to their recommendations.
1:45 PM – 2:30 PM Overview of VA Veterans Benefits Administration (VBA) *Kevin Friel and James Ruhlman*	**SUMMARY:** • Kevin Friel, Assistant Director, Pension and Fiduciary Service, and James Ruhlman, Assistant Director for Policy and Procedures, Education Service, provided an overview of VBA in relation to families, caregivers, and survivors. • VBA has oversight of several different programs: education, life insurance, home loan own guarantee, pension service, and vocational rehabilitation, among others. • VBA manages monetary funds; it recently realigned and divided into districts. • Compensation services is a tax-free benefit for Veterans who have a service-connected illness or injury. • Recently, VBA was able to process and supply benefits to widowed spouses without application within 6 days. • Pension is a needs- and income-based program; it is required that the Veteran has at least one day of war-time service. Mr. Friel noted the following in relation to pensions: o Income threshold must be below poverty level. o Medical expenses are used as a means to reduce reported income. o VBA tries to process claims as fast as possible (avg. 85 days). o VBA wants to automate the process for claims. o Pension has been paying out more over time, which aligns with the economy. o A survivor's pension is also available. • Fiduciary service is available to assist beneficiaries who are unable to manage their funds. o Based on medical evidence, VBA will evaluate whether or not the Veteran is capable of managing their own funds; if they are not capable, VBA will appoint a fiduciary for assistance. • Burial offers funding for three types of services: o Burials not service-connected. o Service-connected burials ($2000 maximum). o Transportation: VBA will reimburse Veterans' transportation to cemetery closest to their home. • Insurance service is the 13th largest in the U.S.; top five in serving Veterans. • Mr. Ruhlman provided the following details regarding education programs: o The Veterans Assisted Education Program (post-Vietnam era) has less than 100 beneficiaries. o The recent Forever GI Bill introduced changes to educational benefits. Changes in business processes based on the legislation are still being developed since it goes into effect in August 2018. ▪ The ability for a Veteran to add a dependent was added; if the service member dies, any of the dependents who have eligibility are allowed to transfer their entitlement across dependents (cannot add dependents following service member's death, but any that are recognized can transfer the entitlement). ▪ If one of the recipients of transferred benefits passes away while the service member is alive, then another can receive entitlement. ▪ Transfer recipient has the same amount of time to use the benefit as the service member (no longer have time limit [previously 15 years]). o Mr. Ruhlman provided details on Dependents' Educational Assistance (DEA): ▪ After August 1, 2018, months will reduce from 45 to 36. ▪ Starting October 1, 2018, the monthly payment rate will jump by 20%.

	• Finally, VBA also offers economic and employment initiatives. **QUESTIONS:** • Ms. Dominique thought the group should consider how to unpack the complexity of VA benefits, and what might be available through public-private partnerships and community services. • Senator Dole asked whether Veterans in the VA Caregiver Program can transfer benefits to the dependents, as these caregivers often become the primary breadwinner for the family and are in need of additional education. o Mr. Ruhlman noted that the Department of Defense (DoD) retains the right to determine the length of time needed for service. • Ms. Buckler asked whether the accuracy of records between the DoD and VA was a concern. o Mr. Ruhlman responded that they are concerned with accuracy and have an active initiative to address this.
2:30 PM – 2:45 PM	Break
2:45 PM – 3:15 PM Overview of VA National Cemetery Administration (NCA) *Ron Walters*	**SUMMARY:** • Ron Walters, Interim Under Secretary for Memorial Affairs, briefed the committee NCA's relationship to families, caregivers, and survivors. • There is a natural link between the mission of NCA and the activities of the committee: to address the needs of Veterans' families across all generations, relationships, and Veteran statuses. o Mr. Walters noted that the benefits of NCA are personalized, and the same care is provided regardless of status on often the most stressful and difficult day of a family members' life—the death of a loved one. o Their mission is to honor Veterans and their families and commemorate their service and sacrifice for our nation. • NCA was established as one of the first formal acts to provide relief to the survivors and families of deceased Veterans. • NCA manages state and tribal cemeteries funded through grant programs. o The cemetery grant program assists states, territories, and tribal governments, in compliance with eligibility requirements, to provide plots where there are no national cemeteries. • Since 2004, NCA has steadily increased burial access—by 2021, 95% of Veterans and their eligible family members (over 20 million) will be able to access a burial option within 75 miles of their home. • About 15% of Veterans choose to be buried in a federal cemetery. The lack of family plots contributes to low utilization rate, as well as inconvenient locations. • However, eligible family members are offered burial at a national cemetery, even if they pass prior to the service member. • Eligibility criteria include: any member of Armed Forces who dies on active duty; any Veteran discharged under honorable conditions; those who are entitled to retired pay; spouses, children, and certain parents. • 36% of burials last year were for non-Veteran family members. • The Veterans Legacy Program provides opportunities for students, teachers, and the general public for strategic and educational partnerships to better understand the influence of Veterans' experiences. o Local cemeteries find a local school to collaborate with and create digital lesson plans based on the lives of interred Veterans. • Secretary Shulkin identified five modernization initiatives for NCA, including greater

	choice, upon which they are acting. o NCA is undergoing expansion; 18 new cemeteries will be opened. o NCA plans to develop an online digital mapping system of gravesites for laptops and an application for mobile phones to scan a headstone and review a Veteran's story. o NCA will partner with local communities and schools to teach the value of military service in a personal context. • NCA participates in the American Customer Satisfaction Index (ACSI), and has scored higher than all other public and private organizations in the survey. • NCA has been able to provide Presidential Memorial Certificates on the date of interment, signed by the president, thanking the next of kin for the service provided by the deceased Service Member. **QUESTIONS:** • Ms. Zinke asked Mr. Walters to summarize the program to help end Veteran homelessness by training them to become NCA caretakers. Mr. Walters reported that NCA had 65 homeless Veterans go through the training program with positive outcomes. They intend to roll it out to other positions beyond the caretaker position. It is a national program, though dependent on need of the local cemeteries.
3:15 PM – 4:30 PM Facilitated Work Group Activity	Prior to breaking out into work groups, Dr. Davis asked the committee to consider the following themes: • Navigation • Importance for VA to understand the feedback of families, caregivers, and survivors o Cultural sensitivity and inclusion of families and caregivers in care planning • Availability, access, flexibility o Rural areas and the unique challenges faced by rural populations • Specific conditions (e.g., mTBI)
4:30 PM – 5:00 PM Report Out	

Tuesday, October 24, 2017

9:05 AM – 9:30 AM Public Comment	• Linda Ambard discussed her experience as a survivor and the effect the death of her husband had on her family. She noted that her son experienced difficulties with substance use and other issues based on his reaction to grief. She noted a widow has three months to decide where they want to live, which she did not know. She described the issues she faced with the military community following the death of her husband. She encouraged the committee to consider allowing surviving spouses the ability to have legal dependents. • Lisa Colella made the suggestion for committee to look into Strength at Home program (12-week rehabilitative program for Veterans struggling with domestic violence and substance abuse) and domestic violence advocate. o Many pre-9/11 partners are uncomfortable seeking domestic violence shelter, and may feel more comfortable going to an advocate in VA that can point them to local programs and resources. o Unlike the civilian population, many domestic violence problems among Veterans are more directly related to a condition they need

treatment for.

- Anna Frese discussed case management as a means to receive feedback from caregivers to VA:
    - Minimally-conscious Veteran required familial support to maintain role as husband and father
    - Veteran now lives with registered caregiver, his mother, and is able to ambulate with assistance and can function despite limited fine motor ability and has been able to return to role as husband and father
    - High quality of life: successful transition from patient to person
    - The OEF/OIF case manager has been critical to working with the family to overcome barriers to care. Despite having a proactive family, there were some limitations to what family members can achieve for Veteran's care.
    - Effective case management has reduced hospital readmissions, and proactive or consistent support can promote Veteran and family resiliency. It is more cost-effective to promote an in-tact family than to care for Veteran in a hospital.
    - Case managers help Veterans and their caregivers in accessing CHOICE program for the Veteran; case manager assisted with usage
    - Challenges with access and awareness of certain beneficial programs (e.g., VD-HCBS, H/HHA) within VA are mitigated by use of a case manager.
    - Case managers provide moderate and consistent support to avoid crisis level, which is costlier in the longer-term.
    - *Need*: (1) support to maintain clinical care; (2) access to VA and non-VA resources; (3) share non-VA resources and authority to maintain care plans
- Brooke Goldberg, Military Officers Association of America (MOAA):
    - Families have confirmed that there is a disparity during the transition from being in uniform and transitioning into VA.
    - There are 3 problem areas where DOD and VA can collaborate: spouse support, financial, behavioral and mental health coverage.
        - Military spouses face unemployment rates four times the national average.
        - Ability to access proper employment resources from DOD ends 180 days after discharge.
    - Demonstrated need from caregiver for support to avoid financial pitfalls, requiring expanded collaboration between DoD and VA to further strengthen existing programs.
    - Mental health services: A Veteran's recovery directly impacts those around them—behavioral and mental health coverage affects family as a whole
    - 365 days to enroll in VA programs (extension beyond existing 180 days window)
- Sharon Hodge, representing Nancy Switzer, mother and caregiver:
    - Husband's medical conditions were constantly deteriorating and she, as a caregiver, needed to monitor his condition every day.
    - Agrees with Dr. Shulkin's suggestion that Veterans reside in the home and receive care outside of a facility setting.
    - Provide caregiver support for all Veterans.
    - Encouraged the Committee to start the dialogue on benefits for pre-

	9/11 Veterans. ○ Suggested that the Committee explore current VA pension program expansions to relieve financial burden and provide respite care to hidden heroes, the caregivers. • Stan White, husband to Committee member Shirley White and father to two Veteran sons who passed away in 2005 and 2008. ○ Medical treatment at VA was ineffective and unnecessarily high drug amounts were used for their son ○ In a matter of 4 months, there were 4 deaths related to one drug within a 25-mile radius of their home. ▪ Peer counseling is vital to treating PTSD. There are many organizations (e.g., Wounded Warrior Project) available to support this effort that should be made easily accessible. ▪ Comradery and counseling is essential to treating PTSD, NOT medication. ▪ Involvement of caregivers is critical. ▪ Mr. White and his wife are advocates of service dogs, equine therapy, music therapy—programs that need to be made available at the local level. ▪ Sometimes medication is needed to stabilize the Veteran, but it cannot be long-term and needs to be weaned off. ▪ There is a need to explore alternative treatments and complementary therapies.
9:40 AM – 9:55 AM VA Geriatric & Gerontology Advisory Committee *W. Clyde Marsh and Dr. Kenneth Shay*	**SUMMARY:** • W. Clyde Marsh, Chair of VA's Geriatric and Gerontology Federal Advisory Committee (GGAC), presented an overview of the committee via PowerPoint presentation. • The Advisory Committee was created in 1980 as a federally-designated committee to advise the Secretary and Under Secretary in all areas of geriatrics and gerontology. • Enrollees in the VA health care system span across a spectrum: over 4 million Veterans are enrolled in the VA health care system, which will climb to 4.5 million as the Veteran population continues to age. • By 2029, the elderly population will reach its peak. There will continue to be more programmatic requirements as the Veteran population continues to age. • Home-based caregivers and facility-based requirements will continue to expand alongside the growth of the aging Veteran population. • GGAC visits Geriatric Research, Education, and Clinical Centers (GRECCs) at least three or four times a year to ensure that they achieve their mandated purposes. • VAMC in Birmingham partners with the University's medical center for expertise in training and research to further efforts to care for the aging population, an effort that is echoed across the nation. • GGAC does not pertain solely to the elderly; it includes care for younger Veterans with disabilities as well. • GGAC provides weekly written reports and site visit reports to supplement the office's annual report, complete with recommendations and insights, that is submitted to Dr. Shulkin and to Congress. • During site visits, the projected needs for eligible Veterans are measured and GGAC surveyors ensure that high quality standard of care are met in VA

	facilities and that research projects are reliable and beneficial to the aging population. • Chairman Marsh reviewed the Office of Geriatric and Extended Care's (GEC's) Continuum of Care, noting that family/caregiver support is needed throughout. The continuum ranges from independent living in the home through end-of-life care in hospice. • VA recognizes that a substantial increase in funding is needed to support the expansion of requirements and the increase in the aging population size. **QUESTIONS:** • Dr. Koffman: There are disproportionate rates of homelessness and substance abuse among Vietnam Veterans, and the life expectancy of a Vietnam Veteran is significantly less than that of a non-Vietnam Veteran. What percentage of Vietnam Veterans are still alive? o Dr. Kenneth Shay will look at VHA statistics and will report back to the Committee by the end of the day.
10:00 AM – 10:10 AM VA Office of Survivor Assistance *Moira Flanders*	**SUMMARY:** • Moira Flanders, Director, VA Office of Survivor Assistance, provided an overview of the services of the VA Office of Survivor Assistance via PowerPoint presentation. • Mission statement: "With malice toward none; with charity for all; with firmness in the right, as God gives us to see right, let us strive to finish the work we are in; To bind up the nation's wounds; To care for him who has borne the battle, and for his widow, and his orphan." • Created in 2008 because of public law embedded in Veterans Improvement Act, including Gold Star Mothers and Wives • Greatest challenge: because there are three administrations, if an individual has a question they must go to a separate point of contact because the administrations are siloed and there is no sharing of databases. • VA Office of Survivor Assistance is placed to reach into any of the three administrations but faces difficulty with cross-collaboration across the administrations. • Data sharing across administrations may improve the Veteran's experience at VA. • The term "survivors" refers to spouses, children, parents, and siblings of those who have served and are either active or retired. • When an active duty service member passes, the Office receives a full list of information about their beneficiaries to start the process of benefits administration. • As reported in 2015, the average time between a service member's passing and the time in which a family member called VA to notify them of death was 7 years. This has since improved, with one recent family phone call to VA placed 45 minutes after the Veteran's passing, though this remains a priority for the Office. • The Office's primary priority is to get the word out to survivors, caregivers, and family members to call VA to receive benefits at the time of the service member's passing. • 98% of paper survey responses indicated that family members did not feel they were adequately informed of benefits they could receive both during the time in which the service member was alive and after they passed away.

	○ Many services and benefits are offered but not enough people know about them; need to get information out to individuals before their service member dies. • VA is able to estimate how many Veterans there are but has no idea how many dependents are supported by these Veterans. 4.4 million Veterans are currently receiving disability compensation, and there is a significant population of Veterans who are not registered with VA and whom VA is unable to reach to care for families and caregivers. • When Veterans pass away, their families and children will be eligible for Disability and Indemnity Compensation (DIC). • There are spouses of those Veterans who will receive a widow's pension; this is not a significant amount but does provide some assistance • For every dollar of DIC, one dollar of Survivor Benefit Plan (SBP) is taken away. VA is providing 100% of DIC but DOD is continually reducing SBP. • When a spouse receives DIC, if the spouse remarries before 57, they will lose their DIC, which is viewed as a sort of punishment for younger spouses if they remarry. Survivors can also lose all benefits for SBP if they remarry before age 55. **QUESTIONS:** • Ms. Dunford: Thanks the Office of Survivor Assistance for their service • Ms. Dominique: Repeatedly hear about folks not knowing about benefits available, as they are rebranding and marketing. Is there a point where there's catastrophic success? How does achieving 75%- 100% impact the budget? ○ Dr. Davis responds: Secretary's goal is to have anyone eligible for any service to be able to access them. There are 9 million Veterans enrolled in the VA health care system and, of those, 6 million are receiving regular care out of 22 million Veterans in the country. Costs are secondary or tertiary issues. Only have 9 million enrollees because other Veterans receive health care from a private source or are not yet ready to choose or are not eligible for services at VA. ○ Want to ensure that 100% of family members know about program assistance. • MG Linnington: Committee may want to change SBP program eligibility and it may require Congressional action but could be included in Secretary's budget request. • Estimate there are about 53 million dependents that could be benefiting from VA services, but who may not be accessible if the Veteran is isolated.
10:10 AM – 12:00 PM Committee Facilitated Discussion	**SUMMARY:** • Ms. Rogers: DoD data systems are not compatible with VA's; some of the issues are already being dealt with, want to ensure that the charge of the subcommittee is to identify issues. ○ Even if issues have plans to be resolved, it is beneficial to discuss, particularly for initiatives that may not have visibility. ○ Ms. Dunford thinks that issues that may have a plan to be fixed should remain on the committee's plate as long as they are outstanding issues. • Ms. Keller: It is difficult to know how to attune age-appropriate services; what is needed for children is different at different ages. Want to avoid program-centered approach and maintain a patient-centered approach.

- BG Sutton: Following the Walter Reed tragedy, there were commissions to study issues around caregiver case management, and the Senior Oversight Committee spent hours to study these issues
    - Committee should go back to read and review these notes to see their progress with implementation.
    - Since that time, 5 years of the task force that followed produced recommendations. There should be a scan of recommendations, what was implemented, what the status of federal coordinators is, and a review of a family comprehensive plan.
- Ms. Buckler: Wants to ensure that self-identification as caregiver remains priority.
- Ms. Zinke: Clear and concise communication of benefits is essential. It is difficult enough for people using the system to understand what is happening without language barriers. When communication is breaking down, what are we doing for people who are minority Veterans and caregivers who may speak a different language or have other cultural sensitivities?
- Dr. Koffman: 2 areas that need to be addressed by the Committee: (1) the absolute importance of public/private partnership; and (2) targeted public health for stratifying population risks (e.g., different health risks for Vietnam Veterans versus OEF/OIF Veterans).
    - Many of the efforts have been for OEF/OIF Veterans, but Vietnam Veterans have unique health needs and risks.
- Discussion of themes across all three workgroups and potential subcommittees:
    - Education and Awareness
        - Increase awareness of benefits among Veterans and family members (e.g., targeted outreach, assessment of available services and identify gaps)
        - Increase awareness of role of caregivers, survivors, and families—empower and clarify roles
        - Reduce stigma and improve the image of VA
    - Access and Eligibility
        - Look at eligibility across all eras, integrate public health approach in looking at all health conditions
        - Flexibility in care: provide for changes in rules, regulations, and metrics for more flexibility
        - Bring in state and local partnerships to expand service capacity
        - Different levels of care at different VAMCs: ensure continuity of care and care coordination
    - Gaps in Innovation
        - Think about new business models or solutions for gaps that have been identified
        - Public/private partnerships may use commercial best practices that can be adapted
        - Could also involve State VSOs and USOs
        - Integrate innovation and best practices
    - Ms. Dominique: One other cross-cutting theme: basic business management (e.g., what are metrics of success, what problem are we trying to solve, what is the strategic road map). Need to know what target state or vision is or what the Committee is trying to measure.

	▪ Education and awareness sub-bullet: "public outreach"—there needs to be an inclusion on the civilian side. o Ms. Buckler: Raising self-awareness and identifying as a caregiver could be added as a separate sub-bullet. Under second subcommittee's bullet, should read "complementary *therapies* and integrative medicine." o Ms. Dorn: It is important to look at the whole picture. She suggests that one overarching theme to add would be a substantial background piece about *why* this issue is so important (both economically and from a humanitarian perspective). There is a lot of data that can be reinforced and form a compelling statement. This Committee is not just a special interest group. o Ms. Comeau: Seeing overlap in areas of "innovation" and "education & awareness" sub-committees; (1) conduct targeted outreach—only 6 million receiving care, many of those committing suicide have not received care at VA; (2) DoD Transition—many caregivers don't get involved until years later, often when TBI progresses; (3) enabling families to receive care at VA—need to have relationship with Veteran and VA as well o Senator Dole: Many caregivers have no doctor or health insurance. It would be ideal for a caregiver to receive a wellness check when the Veteran goes in to receive care. o Ms. Keller: When referring to "families," it is often an adult-centered concept. Request for the inclusion of children as a standalone identity. Groups talk a lot about home as the center of care; would hope that family-centered care is well-represented in subcommittees. ▪ Home-centered care is the ideal but is not always possible—do not want to penalize people if they are not able to achieve receiving care in the home. It is a good goal but is not always possible. o Ms. Dominique: The U.S. has the greatest decline in trust year after year, and corporations could help with trust inclusion. Corporations need to be involved in the solution and in subcommittee focus. o Ms. Dunford: Stressed the importance of home care in eliminating suicidal ideology and feels that it's the wave of the future; need to start viewing initiatives as cost-saving measures in the long-run. The cost of providing care at crisis level is exponentially higher than the primary prevention level. Need to change conversation from budgeting, need to create environment of cost savings and need to change attitude in VA that this is cost prevention. ▪ Dr. Davis: There are some foundational ways to start with Veteran map and look at a process to use data knowledge, metrics, and program evaluation. ▪ Doing an analysis of home health care and arguing for more Veterans to be involved in things like caregiver stipends, which have shown cost savings in keeping the Veteran at home. Different utilization of dependency for higher-cost services. o MG Linnington: In subcommittee 2's focus, home health expansion would be included. o Subcommittees will need to talk to each other across committee

meetings, particularly to flesh out recommendations that pertain to their unique subcommittee's area of focus.

- Ms. Keller: Policy requirements are cross-cutting across all subcommittees; need a lot of fire under something that is already there or can go to the caucus for discussion.
  - Dr. Davis: In recommendations, there may be a request to look back at a previous report. Anything that can be submitted as requests for Dr. Shulkin should be identified because he will be motivated to do anything under his jurisdiction.
- Ms. Carroll: Wants to ensure the Committee is using the term "public/private partnerships" properly; they should not be considered a barrier. "Partnership" is a complicated term. Instead, "collaboration in bringing in all modalities of treatment across both the public and private sectors."
  - Dr. Davis: Will do a cost-benefit analysis to make sure each committee is leveraging existing data. There will be a framework and process that will be presented and made available to each subcommittee.
- Ms. Buckler: Should be "public/private/civic collaboration across all public, private, and civic sectors."
  - Other advisory committees at VA provide status reports that can be shared with this Committee.
- Senator Dole: Key recommendation is to incorporate provider training on how to integrate caregivers into the medical team from day one, particularly in the Education and Awareness area of focus.
- BG Sutton: Caregiver handbooks are being revised with caregiver input at the Traumatic Brain Injury Center. She suggests creating a similar handbook and curriculum for service providers as well.
- Ms. Keller: Curriculum for service providers should have principles extracted and incorporated into institutions such as schools to educate children as well.
- Dr. Davis: In provider education and cultural changes at VA, military cultural sensitivity should also include caregiver, family, and survivor sensitivity in the curriculum for service providers in receiving their licensure at VA.
- Mr. Urena: State directors are valid partners. There are some best practices that can be brought to the table. Trainings are immediate ways to get to Veterans and caregivers at the local level.
- Dr. Koffman: Veterans with PTSD are more likely to be prescribed opioids than non-Veterans. How is this committee going to work in parallel with other VA efforts in this arena?
  - Dr. Davis: If a committee is looking at wellness overall or a specific condition and there are risks associated with addiction and self-medication, rather than have the committee drill into specifics of prescribing practices, work with parallel committee and focus on how the family member of that Veteran will know and become aware of signs of addiction and identifying gaps in service. Participate in an education and outreach campaign.
- Ms. Comeau: "Peer" is an important term for inclusion and for

	awareness within the survivor and caregiver community. In terms of

	cross-cutting themes, peer support should be recognized across all subcommittees.
12:00 PM – 1:00 PM	Lunch
1:00 PM – 1:15 PM Subcommittee Charge and Closing Remarks	**SUMMARY:** Senator Dole appointed subcommittees and described their charge to develop action plans for each of their respective priority areas. • Education and Awareness (Subcommittee 1) Lead: Mary Keller • Access and Eligibility (Subcommittee 2) Lead: Bonnie Carroll • Gaps and Innovation (Subcommittee 3) Lead: Jennifer Dorn

Christine M. Merna

Approved

Christine M. Merna, DFO

Elizabeth Dole

Approved

Sen. Elizabeth Dole, Chair